

2013 Retiree Benefit Election Form



Complete ALL sections – If not enrolling, select “I Decline”. Failure to complete decline statement may disqualify you for the 30 day Special Enrollment Right. **IMPORTANT:** All participants must provide a social security number to enroll. Retirees and/or family members enrolled in a City plan AND eligible for Medicare must complete Section III and provide a copy of your Medicare card to the City.

I. Personal Information - please print

Effective Date _____

Name _____

☐ Retiree (RET) *☐ Surviving Spouse (Surv Sp)

*Name and Social Security Number of City Retiree _____

Daytime Phone _____ Cell Phone _____

Mailing Address: _____

Address Changes? ☐ Yes ☐ No E-mail address _____

II. Retiree & dependent Information

Documentation verifying eligibility must be provided for any dependents you enroll. A list of eligible dependents and the required documentation can be found in the Retiree Benefit Guide.

Relationship and Plan	Name	Birthdate	*Social Security No.	Action
<input type="radio"/> RETIREE <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision				<input type="radio"/> Add <input type="radio"/> Change <input type="radio"/> Drop <input type="radio"/> No change
<input type="radio"/> SPOUSE <input type="radio"/> SURVIVING SPOUSE <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision				<input type="radio"/> Add <input type="radio"/> Change <input type="radio"/> Drop <input type="radio"/> No change
<input type="radio"/> DAUGHTER <input type="radio"/> SON <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision				<input type="radio"/> Add <input type="radio"/> Change <input type="radio"/> Drop <input type="radio"/> No change
<input type="radio"/> DAUGHTER <input type="radio"/> SON <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision				<input type="radio"/> Add <input type="radio"/> Change <input type="radio"/> Drop <input type="radio"/> No change

*Social Security Number is REQUIRED

III. Medicare Information

Last Name, First Name	Relationship	Eligible Date	Effective Date	Medicare Number	(Y= Yes N = No)		
					Part A	Part B	Part D

IV. METLIFE Dental Place an “X” in the appropriate box below:

Plan	Ret or Surv Sp Only	Ret or Surv Sp & one dependent	Ret or Surv Sp & two or more depts.
DHMO	<input type="radio"/> \$10.92	<input type="radio"/> \$20.71	<input type="radio"/> \$31.07
PPO Low	<input type="radio"/> \$14.08	<input type="radio"/> \$27.91	<input type="radio"/> \$49.12
PPO High	<input type="radio"/> \$33.97	<input type="radio"/> \$67.25	<input type="radio"/> \$118.36

☐ I decline DENTAL coverage for: ☐ myself / ☐ my spouse / ☐ my dependent children DUE TO: ☐ Existence of other coverage / ☐ Don't want/need

V. EYEMED Vision Place an “X” in the appropriate box below:

Plan	Ret or Surv Sp Only	Ret or Surv Sp & one dependent	Ret or Surv Sp & two or more depts.
Vision Plan	<input type="radio"/> \$4.49	<input type="radio"/> \$9.40	<input type="radio"/> \$14.32

☐ I decline VISION coverage for: ☐ myself / ☐ my spouse / ☐ my dependent children DUE TO: ☐ Existence of other coverage / ☐ Don't want/need

For office use only:

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Lawson # _____	Medical _____	R x 65 _____
Eff Date _____	Dental _____	Term File _____
Documentation _____	Vision _____	Lawson _____
Coupon Book _____	Med 65 _____	Finance _____

Retiree Medical / Pharmacy Plan Options

REMINDER: The City contribution toward medical coverage is based on the year of your retirement.

Rate charts and summary plan descriptions can be found on the City of Arlington website - www.arlingtontx.gov.

Year of Retirement _____

☐ Retirement before 2008: **Select your Years of Service:** ☐ 10-14 ☐ 15-19 ☐ 20-24 ☐ 25-29 ☐ 30 and over

☐ Retirement after 2007: **Enter your Years of Service:** 10, 11, 12, 13, ..., 30 & Over _____

VI. Under Age 65 Plan Enrollment - UnitedHealthcare Medical & Pharmacy (Rx)

Plan	Select Coverage Level	Enter Your Monthly Cost
<input type="radio"/> Value Medical & Rx	<input type="checkbox"/> RET only <input type="checkbox"/> Spouse only (RET 65+)	\$ _____ Refer to 2013 Monthly Rate Chart at www.arlingtontx.gov
<input type="radio"/> Core Medical & Rx	<input type="checkbox"/> RET + Spouse <input type="checkbox"/> Surv Sp only	
<input type="radio"/> Plus Medical & Rx	<input type="checkbox"/> RET + Child or Children <input type="checkbox"/> Surv Sp + Child or Children	
	<input type="checkbox"/> RET + Family	
<input type="radio"/> I decline MEDICAL and Rx coverage for: <input type="radio"/> myself / <input type="radio"/> my spouse / <input type="radio"/> my dependent children DUE TO: <input type="radio"/> Existence of other coverage / <input type="radio"/> Don't want/need		

VII. Age 65+ Plan Enrollment - UHC Medicare Advantage HMO or AARP Supplement Plan

Note: You must complete the UHC Medicare Advantage HMO and/or AARP Supplement Plan enrollment form and mail it to the address on the form in order to be enrolled in any Age 65+ Plan. To change or drop coverage, you are required to complete a City form AND personally notify UHC Medicare Advantage HMO and/or AARP regarding your change. The City is not authorized to enroll, change, or drop coverage in these plans for you. You will be responsible for 100% of all billings for plans you enroll in if you do not notify both the City and UHC Medicare Advantage HMO and/or AARP of your enrollment change.

Plan	Select Coverage Level	Enter Your Monthly Cost
<input type="radio"/> UHC Medicare Advantage HMO with Rx	<input type="checkbox"/> RET only <input type="checkbox"/> Spouse only (RET <65)	\$ _____ Refer to 2013 Monthly Rate Chart at www.arlingtontx.gov
<input type="radio"/> AARP K Supplement	<input type="checkbox"/> RET + Spouse <input type="checkbox"/> Surv Sp only	
<input type="radio"/> AARP F Supplement		
<input type="radio"/> I decline MEDICAL coverage for: <input type="radio"/> myself / <input type="radio"/> my spouse DUE TO: <input type="radio"/> Existence of other coverage / <input type="radio"/> Don't want/need		

VIII. Age 65+ Pharmacy Plan Enrollment - UHC Medicare Part D Rx Plan

Note: If at any time you are eligible for Medicare Part D and you decline this coverage, you are required to complete the UnitedHealth Rx Part D – Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage form and return to Workforce Services along with this Retiree Benefit Election Form.

Plan	Coverage Level	Years of Service	Your Monthly Cost
<input type="radio"/> UHC Medicare Part D	_____	_____	_____
<input type="radio"/> I decline PART D PHARMACY coverage for: <input type="radio"/> myself / <input type="radio"/> my spouse DUE TO: <input type="radio"/> Existence of other coverage / <input type="radio"/> Don't want/need			

IX. Monthly Cost Payable to City of Arlington Insurance

Enter the cost of each plan you have enrolled here:

\$ _____ + \$ _____ + \$ _____ + \$ _____ + \$ _____ = \$ _____
 Dental Vision Under 65 Medical UHC Medicare Advantage HMO or AARP Plan (65+ Plans) UHC Part D Rx (65+ Plan) Total Payment Due to City Monthly

X. Mailing Address

Enrollment/Change Form:
City of Arlington
Benefits - MS 63-0790
PO Box 90231
Arlington, TX 76004-3231

Monthly Payments:
City of Arlington
Finance Dept. - MS 63-0820
PO Box 90231
Arlington, TX 76004-3231

XI. Signatures

My signature below affirms that my benefit enrollment includes only those dependents that meet the City of Arlington eligibility guidelines. Providing dependent information that is false and/or inaccurate or enrolling dependents that do not meet eligibility guidelines can result in disciplinary action up to and including termination of coverage and/or reimbursement of benefit payments.

RET or Surv Sp

Date

Workforce Services

Date